MANAGED CARE ORGANIZATIONS

Required Services

Q.1. What services are HMOs required to provide during a disaster, civil disorder, etc., to (a) commercial members and (b) Medicare enrollees?

A. (a) Under provisions of Title XIII of the Public Health Service Act (the HMO Act), Federally qualified HMOs are only required to make a "good faith effort" to provide basic health services in the event of a "natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a [HMO]." The "good faith effort" provision relieves HMOs of total responsibility for the provision of services in the event of a disaster, depending on the "limitations on its facilities, personnel, or resources." However, in the case of emergency services that an enrollee receives outside of the health plan, the HMO continues to bear financial responsibility even though the services may not have been pre-authorized by the HMO.

(b) For Medicare enrollees of a Medicare Advantage plan, there exists no "good faith" provision similar to the Public Health Service Act provision. Therefore, Medicare Advantage plans are required to continue directly providing all Part A and Part B services, or otherwise arranging for such services to be provided, so that statutory and regulatory requirements for accessibility and availability of services continue to be met.

For Medicare enrollees, Medicare Advantage plans have financial responsibility for emergency services and "urgently needed" services.

The Medicare Advantage definition of an emergency is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy of the health of the individual or in the case of a pregnant woman, the health of the woman or the unborn child;
- Serious impairment to bodily function, or;
- Serious dysfunction to any bodily organ or part.

Emergency Service means covered inpatient and outpatient services furnished by a provider qualified to furnish emergency services or to evaluate and stabilize emergency conditions.

The term "urgently needed services," are covered services medically necessary and immediately required when the Medicare beneficiary is temporarily outside of the plan’s service area. Medicare Advantage plans are also required to cover

urgently needed services within the service area when, due to unusual and extraordinary circumstances, the organization's provider network is temporarily unavailable or inaccessible, for example because of a natural disaster or electrical power outage.

Urgently needed services are medically necessary and immediately required (1) As a result of an unforeseen illness, injury, or condition; and (2) It was not reasonable, given the circumstances, to obtain the services through the plan's provider network. (9/1/2005)

Emergency Care Coverage/Non-Emergency Care Coverage

Q.2. What do the provisions on emergency and urgently-needed services mean for a Medicare beneficiary?

A. Even in the absence of a disaster, a need for emergency services in or out of the service area of the plan would always be the financial responsibility of the plan. However, because a disaster may make it more difficult, or impossible, to reach the plan's providers, there will be more instances of beneficiaries having to use non-plan providers. CMS would expect plans to employ a liberal interpretation of the provision that obligates the plan to cover emergency care.

For non-emergency services, beneficiaries should first attempt to use the plan's providers. All plans are required to have 24-hour-a-day, 7-day-a-week availability for after-hours health care delivery. A disaster may not necessarily interfere with a plan's ability to arrange for necessary care through the plan provider system or through alternative providers with which the plan has made arrangements to serve the plan's members. (9/1/2005)

General Disaster Policy: Relevant Historical Reference

Q.3. What has CMS's experience been with previous disaster situations as they relate to Medicare Advantage plans?

A. In the case of Hurricane Andrew in South Florida and also the hurricanes in Florida during 2004, Medicare Advantage plans there advised CMS of their intention to be liberal in the interpretation of emergent and urgent care during the worst days of the effects of the hurricane. One health plan, for example, publicly announced that, for beneficiaries residing in a certain geographic area, the plan would pay all claims from all providers for medically necessary care during a specified number of days.

In general, most of the other plans were adopting a liberal claims payment policy but still intended to review and adjudicate each claim individually to determine whether the services were medically necessary, could not reasonably have been delayed, or could not reasonably have been received through the plan's

providers. It is important to recognize that the disaster event may affect each plan's delivery system in different ways. (9/1/2005)

Service Area Coverage

Q.4. How are Medicare Advantage beneficiaries affected if they are forced to remain outside of the plan service area indefinitely because of the effects of a disaster? If beneficiaries disenroll from the plan, could they obtain full Medigap coverage immediately?

A. The regulations provide that Medicare beneficiaries who are absent from the service area for more than 6 consecutive months are deemed to be permanently absent from the service area. With certain exceptions that apply only to some plans that offer continued coverage through affiliates or by not requiring a lock-in, plans are required to disenroll Medicare beneficiaries who are permanently absent from the service area.

Each plan should contact every enrollee whom they intend to disenroll involuntarily to confirm that their absence from the service area will be an extended absence.

Insurability for Medigap supplemental policies is an important issue. In the Hurricane Andrew situation, Blue Cross/Blue Shield of Florida offered Medicare beneficiaries who were forced to disenroll from their plan a Medicare supplemental policy without preexisting condition limitations or waiting periods. (9/1/2005)

Coordination with plan Regulatory Agencies

Q.5. How should CMS interact with other agencies (such as a State Department of Insurance) that regulate Medicare Advantage plans?

A. Generally, State regulatory agencies would be concerned with all types of members of a plan -- not just Medicare members. CMS regional offices should be in touch with State regulatory agencies to provide technical assistance regarding the special needs of Medicare enrollees of plans.

The State regulatory agencies may provide directives or impose requirements on the plans they regulate, which would also affect Medicare members. For example, in the Hurricane Andrew situation, the Florida Department of Insurance issued a written notice to plans in the State outlining the State's expectation that there would be a liberal claims payment policy for medically necessary services that plan enrollees obtained out of plan.

The State regulatory agencies may also be helpful in arranging for Medigap insurers to waive pre-existing condition waiting periods and limitations for

Medicare Advantage enrollees who find it necessary to disenroll from a plan as the result of a disaster. (9/1/2005)

Claims Processing

Q.6. What role should the regional office play in ensuring proper payment by the plans?

A. The regional office may find it necessary to have each plan report on claims processing activity over the period of time during which operations are affected by the disaster or the period of time during which out-of-plan claims will be received by the plan. These two time periods may differ in length. Any reports required of the plan should focus on the special circumstances faced by each plan. (9/1/2005)

Audits

Q.7. Will CMS continue with audits during periods of severe disruptive events?

A. Depending on the nature of the disruptive event and the extent of damage, audits will be suspended until normal operations are reconstituted. (9/1/2005)

General Policy

Q.8. How will CMS assist during emergencies affecting Medicare Advantage (MA) health plans?

A. The RO will contact all Medicare Advantage (MA) health plans with service areas affected by the disruptive event. CMS expects the plans to provide information concerning damage sustained and any instances of interrupted service delivery. The RO will inform the MA plans of the expectation for all medically necessary claims to be paid for all affected areas, even if the services are received out of network. CMS encourages MA plans to initiate liberal claims review policy concerning urgent and emergent care. MA plans should place notices on their websites and telephone lines to inform beneficiaries of this policy. (9/1/2005)

Authorization Policy

Q.9. Should MA plans implement exceptions to its authorization policy?

A. Yes. It is acceptable for MA plans to implement a liberal service authorization policy. In the past, MA plans have approved all urgent requests for authorizations for participating/nonparticipating providers will be approved, including facility transfers to par/non-par hospitals. In addition, most plans approve urgent referral requests. With past emergency situations, plans have

stipulated that for areas sustaining major damage, all pharmacy requests will be filled for either par/non-par pharmacies at par benefits. (9/1/2005)